		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035006

Facility Name: St Patrick's Residence

Address: 1400 Brookdale Rd (Number) Naperville (City) 60563 (Zip Code)

County: DuPage

Telephone Number: 630 416-6565 **Fax #** 630 416-1364

IDPA ID Number: 36-2527011 001

Date of Initial License for Current Owners: 03/07/1965

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Robert A. Gancarz **Telephone Number:** 630 753-1502

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) 04/30/2002 (Date)
(Type or Print Name) Sister Anthony Veilleux
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	136	Intermediate (ICF)	146	51,470	3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	22	9,850	5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,650	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	716	12,589	1,257	14,562	8
9	SNF/PED					9
10	ICF	34,957	16,464		51,421	10
11	ICF/DD					11
12	SC	4,704	4,689		9,393	12
13	DD 16 OR LESS					13
14	TOTALS	40,377	33,742	1,257	75,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.34%

D. How many bed-hold days during this year were paid by Public Aid?
161 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/22/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/22/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 1,257

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/2001 Fiscal Year: 12/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	614,807	67,684	48,615	731,106		731,106	(27,442)	703,664			1
2	Food Purchase		452,781		452,781		452,781	(9,712)	443,069			2
3	Housekeeping	438,032	47,174		485,206		485,206	(22,044)	463,162			3
4	Laundry	214,372	27,101	1,952	243,425		243,425	(12,332)	231,093			4
5	Heat and Other Utilities			222,524	222,524		222,524	(8,632)	213,892			5
6	Maintenance	215,287	25,989	31,377	272,653		272,653	14,915	287,568			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,482,498	620,729	304,468	2,407,695		2,407,695	(65,247)	2,342,448			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,532,054	209,189	2,050,333	4,791,576		4,791,576		4,791,576			10
10a	Therapy	114,913	5,418		120,331		120,331		120,331			10a
11	Activities	161,302	3,748	3,234	168,284		168,284		168,284			11
12	Social Services	174,663			174,663		174,663		174,663			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,982,932	218,355	2,071,567	5,272,854		5,272,854		5,272,854			16
	C. General Administration											
17	Administrative	241,348		5,850	247,198		247,198	(5,850)	241,348			17
18	Directors Fees											18
19	Professional Services			96,566	96,566		96,566		96,566			19
20	Dues, Fees, Subscriptions & Promotions			70,316	70,316		70,316	(4,213)	66,103			20
21	Clerical & General Office Expenses	228,685	39,007	76,665	344,357		344,357	(37,560)	306,797			21
22	Employee Benefits & Payroll Taxes			830,314	830,314		830,314	(11,779)	818,535			22
23	Inservice Training & Education			5,015	5,015		5,015		5,015			23
24	Travel and Seminar			3,825	3,825		3,825	(3,824)	1			24
25	Other Admin. Staff Transportation			7,583	7,583		7,583		7,583			25
26	Insurance-Prop.Liab.Malpractice			105,728	105,728		105,728	(4,418)	101,310			26
27	Other (specify):*											27
28	**TOTAL General Administration**	470,033	39,007	1,201,862	1,710,902		1,710,902	(67,644)	1,643,258			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,935,463	878,091	3,577,897	9,391,451		9,391,451	(132,891)	9,258,560			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Patrick's Residence #0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			537,880	537,880		537,880		537,880			30
31	Amortization of Pre-Op. & Org.			7,667	7,667		7,667		7,667			31
32	Interest			291,448	291,448		291,448	(73,487)	217,961			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			836,995	836,995		836,995	(73,487)	763,508			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		351,805	105,854	457,659		457,659		457,659			39
40	Barber and Beauty Shops	58,966	1,938	4,727	65,631		65,631	(70,541)	(4,910)			40
41	Coffee and Gift Shops		21,691		21,691		21,691	(34,732)	(13,041)			41
42	Provider Participation Fee			100,815	100,815		100,815		100,815			42
43	Other (specify):*	57,826		130,777	188,603		188,603	(188,603)				43
44	**TOTAL Special Cost Centers**	116,792	375,434	342,173	834,399		834,399	(293,876)	540,523			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,052,255	1,253,525	4,757,065	11,062,845		11,062,845	(500,254)	10,562,591			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(73,487)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,850)	17		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,847)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (104,184)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(81,444)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (81,444)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (185,628)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Patrick's Residence

ID# 0035006

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Investment Expense	$ (9,000)	21	1
2	Development Salary	(57,826)	43	2
3	Development Expense	(52,295)	43	3
4	Fund Raising Expense	(77,487)	43	4
5	Barber & Beauty Income	(70,541)	40	5
6	Coffee & Gift Shop Income	(34,732)	41	6
7	Stamp Income	(1,100)	21	7
8	Happy Hour Expense	(2,613)	21	8
9	Public Relations	(995)	43	9
10	Undocumented Travel & Seminar Expense	(3,824)	24	10
11	Promotional Advertising	(4,213)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(314,626)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	(27,442)	0	0	0	0	0	0	0	0	0	(27,442)	1
2	Food Purchase	0	(9,712)	0	0	0	0	0	0	0	0	0	(9,712)	2
3	Housekeeping	0	(22,044)	0	0	0	0	0	0	0	0	0	(22,044)	3
4	Laundry	0	(12,332)	0	0	0	0	0	0	0	0	0	(12,332)	4
5	Heat and Other Utilities	0	(8,632)	0	0	0	0	0	0	0	0	0	(8,632)	5
6	Maintenance	0	14,915	0	0	0	0	0	0	0	0	0	14,915	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(65,247)	0	0	0	0	0	0	0	0	0	(65,247)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(5,850)	0	0	0	0	0	0	0	0	0	0	(5,850)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,213)	0	0	0	0	0	0	0	0	0	0	(4,213)	20
21	Clerical & General Office Expenses	(37,560)	0	0	0	0	0	0	0	0	0	0	(37,560)	21
22	Employee Benefits & Payroll Taxes	0	(11,779)	0	0	0	0	0	0	0	0	0	(11,779)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,824)	0	0	0	0	0	0	0	0	0	0	(3,824)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(4,418)	0	0	0	0	0	0	0	0	0	(4,418)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(51,447)	(16,197)	0	0	0	0	0	0	0	0	0	(67,644)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,447)	(81,444)	0	0	0	0	0	0	0	0	0	(132,891)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(73,487)	0	0	0	0	0	0	0	0	0	0	(73,487)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(73,487)	0	0	0	0	0	0	0	0	0	0	(73,487)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(70,541)	0	0	0	0	0	0	0	0	0	0	(70,541)	40
41	Coffee and Gift Shops	(34,732)	0	0	0	0	0	0	0	0	0	0	(34,732)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(188,603)	0	0	0	0	0	0	0	0	0	0	(188,603)	43
44	**TOTAL Special Cost Centers**	(293,876)	0	0	0	0	0	0	0	0	0	0	(293,876)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(418,810)	(81,444)	0	0	0	0	0	0	0	0	0	(500,254)	45

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Carmelite Sisters	100.00	None		Carmelite System	Germantown	Religious Order

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$ 27,442	Carmelite Sisters of the Aged and Infirm		$	$ (27,442)	1
2	V	2	Food Purchase	28,160	Carmelite Sisters of the Aged and Infirm		18,448	(9,712)	2
3	V	3	Housekeeping	22,044	Carmelite Sisters of the Aged and Infirm			(22,044)	3
4	V	4	Laundry	12,332	Carmelite Sisters of the Aged and Infirm			(12,332)	4
5	V	5	Utilities	16,985	Carmelite Sisters of the Aged and Infirm		8,353	(8,632)	5
6	V	6	Maintenance	26,935	Carmelite Sisters of the Aged and Infirm		41,850	14,915	6
7	V	22	Employee Benefits	11,779	Carmelite Sisters of the Aged and Infirm			(11,779)	7
8	V	26	Insurance	4,418	Carmelite Sisters of the Aged and Infirm			(4,418)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 150,095			$ 68,651	$ * (81,444)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	City of Naperville-USBank		X	Mortgage		12/19/98	$ 6,820,000	$ 5,818,000	01/01/2013	0.0491	$ 291,448	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,820,000	$ 5,818,000			$ 291,448	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,820,000	$ 5,818,000			$ 291,448	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Patrick's Residence COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035006

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 118,218 B. General Construction Type: Exterior CMV Block Frame Pre-Cast Concrete Number of Stories Three

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 116,922
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 7,667
4. Dates Incurred: 1997

Nature of Costs: Bond Issuance Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	7.33 Acres	1987	$ 638,590	1
2					2
3	TOTALS	7		$ 638,590	3

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	210		1989	1989	$ 7,786,645	$ 271,499	40	$ 271,499	$	$ 3,469,734	4
5			1997	1997	2,194,676	54,867	40	54,867		246,901	5
6			2000	2000	2,987,034	38,633	40	38,633		57,438	6
7											7
8											8
	Improvement Type**										
9	Various-Land Improvements			1990	128,000	8,867	15	8,867		111,148	9
10	Various-Land Improvements			1993	22,602		10			26,789	10
11	Various-Land Improvements			1994	1,501	75	20	75		567	11
12	Various-Building Improvements			1991	4,862	324	15	324		3,564	12
13	Various-Building Improvements			1993	6,887	665	10	665		5,410	13
14	Various-Building Improvements			1994	30,111	2,597	15	2,597		18,918	14
15	Beauty Shop Improvements			1996	2,417	242	10	242		1,390	15
16	Business Office Improvements			1996	559	27	5	27		559	16
17	Chapel Landscaping			1997	15,237	762	20	762		3,429	17
18	Chapel Landscaping			1997	14,000	700	20	700		3,150	18
19	Chapel Landscaping			1997	11,363	568	20	568		2,556	19
20	Smoke Alarms			1997	9,000	1,800	5	1,800		8,100	20
21	Carpentry			1997	1,966	393	5	393		1,769	21
22	B Gunther Co Improvements			1997	1,000	200	5	200		900	22
23	Security System-Magnetic Doors			1998	4,949	494	10	494		1,729	23
24	Replace Mortar-Structural Preservation			1998	5,744	574	10	574		2,009	24
25	Stained Glass Windows-Robt Harmon			1998	14,500	362	40	362		1,267	25
26	Landscaping Trees			1998	3,022	152	20	152		529	26
27	Outside Signage-St Joes			1999	3,200	160	10	160		400	27
28	Magnetic Doors-First Security			1999	3,632	363	10	363		908	28
29	Repaved Parking Lot-Paveman			2000	6,838	342	20	342		513	29
30	Outside Awning-Accent Awning Co			2000	2,398	120	20	120		180	30
31	Replace Mortar-Structural Preservation			2000	7,345	368	20	368		552	31
32	Cooling System Pump-SW Town			2001	10,440	261	20	261		261	32
33	Architect Fees-Paul Straka			2001	2,418						33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,282,346	$ 385,415		$ 385,415	$	$ 3,970,670	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,001,551	$ 130,990	$ 130,990	$	5 & 10	$ 1,570,446	71
72	Current Year Purchases	203,755	12,847	12,847		5 & 10	12,847	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,205,306	$ 143,837	$ 143,837	$		$ 1,583,293	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1996 Pontiac Van	1996	$ 22,444	$	$	$	4	$ 22,444	76
77	Facility Business	1994 Ford Bus	1994	39,951	4,001	4,001		10	31,660	77
78	Facility Business	1996 Dodge Pickup	2000	23,116	4,627	4,627		5	6,939	78
79										79
80	TOTALS			$ 85,511	$ 8,628	$ 8,628	$		$ 61,043	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,211,753	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 537,880	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 537,880	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,615,006	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 14,252	$		$ 14,252	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,062			9,062	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			29,926			29,926	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				264,301		264,301	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule					52,614	87,504		140,118	13
14	TOTAL			$		$ 105,854	$ 351,805		$ 457,659	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,908,390	$	1
2	Cash-Patient Deposits	29,067		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 51,000)	1,026,576		3
4	Supply Inventory (priced at Cost)	21,940		4
5	Short-Term Investments			5
6	Prepaid Insurance	42,373		6
7	Other Prepaid Expenses	25,803		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,054,149	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	638,590		13
14	Buildings, at Historical Cost	13,077,354		14
15	Leasehold Improvements, at Historical Cost	202,563		15
16	Equipment, at Historical Cost	2,293,235		16
17	Accumulated Depreciation (book methods)	(5,615,009)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Bond Issuance Costs	85,673		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,682,406	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,736,555	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 541,112	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,067		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	410,067		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,755		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	146,006		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	14,659		36
37	Medicare Settlement	1,975		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,145,641	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	40,391		39
40	Mortgage Payable			40
41	Bonds Payable	5,818,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,858,391	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,004,032	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,732,523	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,736,555	$	48

***(See instructions.)**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,785,445	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,785,445	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(168,538)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	115,616	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (52,922)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 7,732,523	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,416,420	1
2	Discounts and Allowances for all Levels	(2,264,505)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,151,915	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	259,998	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 259,998	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	34,970	12
13	Barber and Beauty Care	70,541	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	24,617	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,873	19
20	Radiology and X-Ray	97,638	20
21	Other Medical Services	43,599	21
22	Laundry	3,000	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 325,237	23
	D. Non-Operating Revenue		
24	Contributions	260,002	24
25	Interest and Other Investment Income***	73,487	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 333,488	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**	4,306	27
28	**Gain(loss) on Investments**	(181,950)	28
28a	**Vending Machine**	1,314	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (176,331)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,894,307	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,407,695	31
32	Health Care	5,272,854	32
33	General Administration	1,710,902	33
	B. Capital Expense		
34	Ownership	836,995	34
	C. Ancillary Expense		
35	Special Cost Centers	733,584	35
36	Provider Participation Fee	100,815	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,062,845	40
41	**Income before Income Taxes (line 30 minus line 40)****	(168,538)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (168,538)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,070	2,410	$ 61,885	$ 25.68	1
2	Assistant Director of Nursing	2,160	2,320	54,468	23.48	2
3	Registered Nurses	20,732	23,359	501,443	21.47	3
4	Licensed Practical Nurses	23,712	26,660	500,524	18.77	4
5	Nurse Aides & Orderlies	101,603	110,158	1,358,809	12.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,080	2,240	52,718	23.53	7
8	Rehab/Therapy Aides	3,885	4,339	62,195	14.33	8
9	Activity Director	1,960	2,080	27,502	13.22	9
10	Activity Assistants	9,094	9,861	133,800	13.57	10
11	Social Service Workers	8,857	9,651	174,663	18.10	11
12	Dietician	2,080	2,480	51,026	20.58	12
13	Food Service Supervisor	3,928	4,398	63,306	14.39	13
14	Head Cook	3,596	4,416	66,379	15.03	14
15	Cook Helpers/Assistants	4,011	4,455	49,612	11.14	15
16	Dishwashers	43,831	48,196	384,484	7.98	16
17	Maintenance Workers	14,865	16,230	215,287	13.26	17
18	Housekeepers	37,458	42,255	438,032	10.37	18
19	Laundry	24,276	27,492	214,372	7.80	19
20	Administrator	2,400	2,520	66,281	26.30	20
21	Assistant Administrator	2,400	2,520	57,559	22.84	21
22	Other Administrative	1,920	2,120	54,691	25.80	22
23	Office Manager	2,043	2,192	62,817	28.66	23
24	Clerical	14,427	16,235	228,685	14.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	4,568	4,899	54,925	11.21	32
33	Other(specify) Dvlpmt/Beauty	6,068	6,635	116,792	17.60	33
34	TOTAL (lines 1 - 33)	344,024	380,121	$ 5,052,255 *	$ 13.29	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	9-3	36
37	Medical Records Consultant	88	3,872	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,420	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	604	10-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	100	$ 23,896		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	21,913	$ 860,101	10-3	50
51	Licensed Practical Nurses	2,699	97,157	10-3	51
52	Nurse Aides	53,723	1,087,883	10-3	52
53	TOTAL (lines 50 - 52)	78,335	$ 2,045,141		53

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sister Anthony	Administrator		$ 66,281
Sister Jeanne	Asst Admnstrtr		57,559
Robert Gancarz	Controller		62,817
Ken Deardorff	HR Director		54,691
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 241,348

B. Administrative - Other

Description	Amount
Government Fine	$ 5,850
TOTAL (agree to Schedule V, line 17, col. 3)	$ 5,850
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PriceWaterhouseCoopers	Auditing	$ 24,300
Frost,Ruttenburg & Rothblatt	Medicare Consulting	8,739
Katten, Muchin & Zavis	Legal	35,584
CHCS	Survey Consulting	9,200
Practical System Solutions	Computer Consulting	8,330
Medinet	Billing	1,040
Margolis, Marmel & Crosby	Tax Consulting	2,485
Radius Consulting Group	Medicaid Consulting	2,500
Systematic Mgmt Systems	Part B Billing	4,388
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 96,566

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 94,200
Unemployment Compensation Insurance	4,200
FICA Taxes	342,552
Employee Health Insurance	251,292
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life & Disability Insurance	35,848
Pension	94,161
Staff Development	6,300
Employee Physicals & vaccination	1,761
TOTAL (agree to Schedule V, line 22, col.8)	$ 830,314

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	42,878
Health Care Worker Background Check	1,500
(Indicate # of checks performed 214)	
Association Fees	9,341
Dues And Subscriptions	12,384
Promotional Advertising	4,213
Less: Public Relations Expense	( )
Non-allowable advertising	(4,213)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,103

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Patrick's Residence # 0035006 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $9,341**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **115,380** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **100,815**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ ____
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Y**
Firm Name: **PriceWaterhouseCoopers** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Board of Directors Listing

Bishop Joseph L Imesch

Reverend William E. Donnelly

Sister M. shawn Bernadette Flynn, O. Carm

Sister M. Kevin Patricia Lynch, O. Carm

Sr M. Paul Anthony Videtich, O. Carm

Sr Ann McCartney, O. Carm

Sr Norah Michael McNamara, O. Carm

Sr Mary Rose Heery, O. Carm

Sr Ann Elizabeth Brown, O. Carm

Mr. Carmen S. DiGiovine
Mr. John J. Durso
Mrs. Nancy Gorman
Mr. Raymond E. Jones
Miss Josephine Mancuso
Mr. Ron Santo

Supplemental Schedule of Medical Supplies
Line 13

Special Services-Supplies (column 6-Supplies)		$ Amount
1 X-Ray Services		80,574
2 EKG Services		6,930
Total	39-2	87,504

Outside Therapies (Column 5- Cost)		$ Amount
1 Medicare Part A Therapies		52,614
Total	39-3	52,614